

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0040428</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Maplewood Care</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>50 North Jane Drive</u> <u>Elgin</u> <u>60123</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Kane</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>(847) 697-3750</u> <b>Fax #</b> <u>(847) 697-5385</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>	
<b>IDPA ID Number:</b> <u>363868385001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>04/01/93</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428 Report Period Beginning: 01/01/03 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,095</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>203</u>	TOTALS	<u>203</u>	<u>74,095</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,748</u>	<u>1,416</u>	<u>885</u>	<u>19,049</u>	8
9	SNF/PED					9
10	ICF	<u>39,078</u>	<u>3,306</u>	<u>16</u>	<u>42,400</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>55,826</u>	<u>4,722</u>	<u>901</u>	<u>61,449</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 82.93%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 4/1/93

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 4/1/93 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 23 and days of care provided 770Medicare Intermediary AdminaStar - Kentucky

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number      **Maplewood Care**#      **0040428**Report Period Beginning:      **01/01/03**Ending:      **12/31/03****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	216,069	24,035	33,912	274,016		274,016	(19,445)	254,571		1
2	Food Purchase		281,414		281,414	(31,043)	250,371	(215)	250,155		2
3	Housekeeping	189,417	18,409		207,826		207,826	158	207,984		3
4	Laundry	47,204	26,863		74,067		74,067		74,067		4
5	Heat and Other Utilities			148,088	148,088		148,088	2,118	150,206		5
6	Maintenance	65,056	26,758	95,759	187,573		187,573	(27,510)	160,063		6
7	Other (specify):*							5,995	5,995		7
8	<b>TOTAL General Services</b>	517,746	377,479	277,759	1,172,984	(31,043)	1,141,941	(38,899)	1,103,042		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,484,157	71,636	471,223	2,027,016		2,027,016	(27,708)	1,999,308		10
10a	Therapy	138,980	4,618	17,730	161,328		161,328	(3,750)	157,578		10a
11	Activities	84,534	8,436	2,688	95,658		95,658		95,658		11
12	Social Services	140,675	46	14,593	155,314		155,314		155,314		12
13	Nurse Aide Training										13
14	Program Transportation			190	190		190		190		14
15	Other (specify):*							5,218	5,218		15
16	<b>TOTAL Health Care and Programs</b>	1,848,346	84,736	512,424	2,445,506		2,445,506	(26,240)	2,419,266		16
	<b>C. General Administration</b>										
17	Administrative	57,230		75,552	132,782		132,782	(451)	132,331		17
18	Directors Fees										18
19	Professional Services			240,073	240,073	(134)	239,939	(127,273)	112,666		19
20	Dues, Fees, Subscriptions & Promotions			49,883	49,883		49,883	(27,662)	22,221		20
21	Clerical & General Office Expenses	168,576	22,811	72,605	263,992		263,992	19,443	283,435		21
22	Employee Benefits & Payroll Taxes			338,444	338,444	31,043	369,487	(442)	369,045		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,424	4,424		4,424	471	4,895		24
25	Other Admin. Staff Transportation			4,400	4,400		4,400	2,747	7,147		25
26	Insurance-Prop.Liab.Malpractice			169,794	169,794		169,794	1,106	170,900		26
27	Other (specify):*							20,467	20,467		27
28	<b>TOTAL General Administration</b>	225,806	22,811	955,175	1,203,792	30,909	1,234,701	(111,594)	1,123,107		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,591,898	485,026	1,745,358	4,822,282	(134)	4,822,148	(176,734)	4,645,414		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Maplewood Care

#0040428

Report Period Beginning:

01/01/03

Ending:

12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			78,790	78,790		78,790	(10,463)	68,327			30
31	Amortization of Pre-Op. & Org.							16,587	16,587			31
32	Interest			103,792	103,792		103,792	519,169	622,961			32
33	Real Estate Taxes			105,623	105,623	134	105,757	5,978	111,735			33
34	Rent-Facility & Grounds			516,000	516,000		516,000	(516,000)				34
35	Rent-Equipment & Vehicles			10,611	10,611		10,611	6,256	16,867			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			814,816	814,816	134	814,950	21,527	836,477			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,003	29,005	78,008		78,008		78,008			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,143	111,143		111,143		111,143			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		49,003	140,148	189,151		189,151		189,151			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,591,898	534,029	2,700,322	5,826,249		5,826,249	(155,207)	5,671,042			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Maplewood Care

# 0040428

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(31,649)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(215)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(985)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,976)	21		24
25	Fund Raising, Advertising and Promotional	(6,466)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,370)	20		28
29	Other-Attach Schedule	(40,524)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (127,186)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(28,021)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (28,021)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (155,207)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Magnetwood Care

ID# 0040228

Report Period Beginning:

01/01/03

Ending:

12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Other Income	(13)	21	1
2	Theft & Damage	(684)	21	2
3	Trip Fees	(159)	21	3
4	IL Council - COPE	(1,406)	20	4
5	Legal - Nonallowable	(26,067)	19	5
6	Capitalized RAM	(11,361)	86	6
7	Penalty	(16,206)	20	7
8				8
9				9
10				10
11				11
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98				98
99				99
100				100
101	Total	(49,524)		101

## STATE OF ILLINOIS

## Summary A

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/03

Ending:

12/31/03

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary					(19,445)							(19,445)	1
2	Food Purchase	(215)											(215)	2
3	Housekeeping			676				(518)					158	3
4	Laundry													4
5	Heat and Other Utilities			872	1,246								2,118	5
6	Maintenance	(11,561)		688	(12,344)	(4,293)							(27,510)	6
7	Other (specify):*				929	5,066							5,995	7
8	<b>TOTAL General Services</b>	(11,776)		2,236	(10,169)	(18,672)		(518)					(38,899)	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records				(20,937)			(6,771)					(27,708)	10
10a	Therapy					(3,750)							(3,750)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				4,099	1,119							5,218	15
16	<b>TOTAL Health Care and Programs</b>				(16,838)	(2,631)		(6,771)					(26,240)	16
	<b>C. General Administration</b>													
17	Administrative			16,751	(62,958)	45,756							(451)	17
18	Directors Fees													18
19	Professional Services	(20,067)		(99,092)	(16,215)	8,101							(127,273)	19
20	Fees, Subscriptions & Promotions	(27,930)		194	74								(27,662)	20
21	Clerical & General Office Expenses	(35,763)		55,330	(124)								19,443	21
22	Employee Benefits & Payroll Taxes						(442)						(442)	22
23	Inservice Training & Education													23
24	Travel and Seminar			163	308								471	24
25	Other Admin. Staff Transportation			760	1,987								2,747	25
26	Insurance-Prop.Liab.Malpractice			384	722								1,106	26
27	Other (specify):*			9,846	3,087	7,534							20,467	27
28	<b>TOTAL General Administration</b>	(83,760)		(15,664)	(73,119)	61,391	(442)						(111,594)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(95,536)		(13,428)	(100,126)	40,088	(442)	(7,289)					(176,734)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(31,649)	15,921	2,428	2,837								(10,463)	30
31	Amortization of Pre-Op. & Org.		16,587										16,587	31
32	Interest		516,000	662	2,507								519,169	32
33	Real Estate Taxes			2,235	3,743								5,978	33
34	Rent-Facility & Grounds		(516,000)										(516,000)	34
35	Rent-Equipment & Vehicles			2,189	4,067								6,256	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	(31,649)	32,508	7,514	13,154								21,527	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													44
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(127,186)	32,508	(5,914)	(86,972)	40,088	(442)	(7,289)					(155,207)	45



Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/03Ending: 12/31/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule		See Attached Schedule		See Attached Schedule		
				Maplewood-Jane, LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rental Income	\$ 516,000	Maplewood-Jane, LLC	100.00%	\$	\$ (516,000)
2	V	33 Income - Real Estate Taxes	105,623	Maplewood-Jane, LLC	100.00%		(105,623)
3	V	31 Amortization		Maplewood-Jane, LLC	100.00%	16,587	16,587
4	V	30 Depreciation		Maplewood-Jane, LLC	100.00%	15,921	15,921
5	V	32 Interest Expense		Maplewood-Jane, LLC	100.00%	516,000	516,000
6	V	33 Real Estate Tax Expense		Maplewood-Jane, LLC	100.00%	105,623	105,623
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 621,623			\$ 654,131	\$ * 32,508

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 676	\$ 676
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	872	872
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	688	688
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	16,751	16,751
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,138	2,138
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	194	194
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	55,330	55,330
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	163	163
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	760	760
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	384	384
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	9,846	9,846
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,428	2,428
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	662	662
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,235	2,235
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,189	2,189
30	V						
31	V						
32	V	19 ACCOUNT./BOOKKEEPING	101,230	PREFERRED BOOKKEEPING	100.00%		(101,230)
33	V	19 COMPUTER	4,872	PREFERRED BOOKKEEPING	100.00%	4,872	
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 106,102			\$ 100,188	\$ * (5,914)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Maplewood Care**# **0040428**Report Period Beginning: **01/01/03**Ending: **12/31/03****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,246	\$ 1,246
16	V	6 REPAIRS AND MAINT.	18,276	S.I.R. MANAGEMENT, INC.	100.00%	5,932	(12,344)
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	929	929
18	V	10 NURSING	40,200	S.I.R. MANAGEMENT, INC.	100.00%	19,263	(20,937)
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,099	4,099
20	V	17 ADMINISTRATIVE	71,232	S.I.R. MANAGEMENT, INC.	100.00%	8,274	(62,958)
21	V	19 PROFESSIONAL FEES	16,440	S.I.R. MANAGEMENT, INC.	100.00%	225	(16,215)
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	74	74
23	V	21 CLERICAL & GENERAL	20,712	S.I.R. MANAGEMENT, INC.	100.00%	20,588	(124)
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	308	308
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	1,987	1,987
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	722	722
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,087	3,087
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,837	2,837
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	2,507	2,507
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,743	3,743
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,067	4,067
32	V						
33	V	35 LEASED EQUIPMENT		S.I.R. MANAGEMENT, INC.	100.00%		
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%		
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 166,860			\$ 79,888	\$ * (86,972)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	\$ 20,712	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,076	\$ (14,636)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,292	1,292	16
17	V	17	ADMIN/LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	50,076	50,076	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	12,973	12,973	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	7,534	7,534	19
20	V								20
21	V	17	ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%			21
22	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V								23
24	V	17	ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%			24
25	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%			25
26	V								26
27	V	10A	SPECIAL REHAB	9,012	S.I.R. MANAGEMENT, INC.	100.00%	5,262	(3,750)	27
28	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,119	1,119	28
29	V								29
30	V	6	REPAIRS AND MAINT.	13,608	S.I.R. MANAGEMENT, INC.	100.00%	9,315	(4,293)	30
31	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,981	1,981	31
32	V								32
33	V	1	DIETICIAN SALARIES	13,200	S.I.R. MANAGEMENT, INC.	100.00%	8,391	(4,809)	33
34	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,793	1,793	34
35	V								35
36	V	19	LEGAL FEES	4,872	S.I.R. MANAGEMENT, INC.	100.00%		(4,872)	36
37	V								37
38	V	17	COUNCIL DUES	4,320	S.I.R. MANAGEMENT, INC.	100.00%		(4,320)	38
39	Total			\$ 65,724			\$ 105,812	\$ * 40,088	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 104,873	\$ 104,873	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	105,315	CCS EMPLOYEE BENEFIT GROUP	100.00%		(105,315)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 105,315			\$ 104,873	\$ * (442)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 DIETARY	\$	XCEL MEDICAL SUPPLY, LLC	100.00%	\$	\$
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%		
17	V	03 HOUSEKEEPING	3,933	XCEL MEDICAL SUPPLY, LLC	100.00%	3,415	(518)
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%		
19	V	06 REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%		
20	V	10 NURSING	51,443	XCEL MEDICAL SUPPLY, LLC	100.00%	44,672	(6,771)
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%		
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%		
25	V	39 ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%		
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 55,376			\$ 48,087	\$ * (7,289)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name & ID Number      Maplewood Care      #      0040428      Report Period Beginning:      01/01/03      Ending:      12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Owner	Clerical	2.96%	See Attached	0.54	1.35%	Alloc. Salary	\$ 420	22-7	1
2	Nenita Guzman	Relative	Dietary		See Attached	4.79	9.58%	Alloc. Salary	6,076	1-7	2
3	Louise Bergthold	Owner	Administrative	5.91%	See Attached	5.27	9.58%	Alloc. Salary	17,070	17-7	3
4	Tom Winter	Owner	Administrative	0.74%	See Attached	6.49	10.82%	Alloc. Salary	16,751	17-7	4
5	Jeff Oravec	Owner	Administrative	0.49%	See Attached	3.83	9.58%	Alloc. Salary	9,054	17-7	5
6	Joey Abramchik	Owner	Administrative	2.46%	See Attached	4.31	9.58%	Alloc. Fees	12,973	17-7	6
7	Stuart Sikes	Owner	Administrative	0.99%	See Attached	3.83	9.58%	Alloc. Salary	11,435	17-7	7
8	Eric Rothner	Relative	Administrative		See Attached	0.53	0.96%	Alloc. Salary	13,816	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 87,595		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization PREFERRED BOOKKEEPING SERVICES  
 Street Address 4100 WEST PRATT AVE.  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 674-5200  
 Fax Number ( 847) 674-5267

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	935,658	11	\$ 6,250	\$ 101,230	\$ 676	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	935,658	11	8,058	101,230	872	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	935,658	11	6,361	101,230	688	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	935,658	11	154,828	101,230	16,751	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	935,658	11	19,761	101,230	2,138	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	935,658	11	1,793	101,230	194	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	935,658	11	511,408	101,230	55,330	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	935,658	11	1,508	101,230	163	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	935,658	11	7,028	101,230	760	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	935,658	11	3,553	101,230	384	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	935,658	11	91,005	101,230	9,846	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	935,658	11	22,443	101,230	2,428	12
13	32	INTEREST	BOOK./ACCNT.INCOME	935,658	11	6,117	101,230	662	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	935,658	11	20,656	101,230	2,235	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	935,658	11	20,229	101,230	2,189	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					4,872	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 880,998	\$ 608,675	\$ 100,188		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.Street Address 6840 N. LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number ( 847) 675 -7979Fax Number ( 847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	641,706	10	\$ 13,016	\$	61,449	\$ 1,246	1
2	6 REPAIRS AND MAINT.	PATIENT DAYS	641,706	10	61,951		61,449	5,932	2
3	7 EMP. BEN.-GEN. SERV.	PATIENT DAYS	641,706	10	9,705		61,449	929	3
4	10 NURSING	PATIENT DAYS	641,706	10	201,162	201,162	61,449	19,263	4
5	15 EMP. BEN.-H.C.	PATIENT DAYS	641,706	10	42,801		61,449	4,099	5
6	17 ADMINISTRATIVE	PATIENT DAYS	641,706	10	86,401	86,401	61,449	8,274	6
7	19 PROFESSIONAL FEES	PATIENT DAYS	641,706	10	2,349		61,449	225	7
8	20 FEES,SUBSCRIPTIONS	PATIENT DAYS	641,706	10	773		61,449	74	8
9	21 CLERICAL & GENERAL	PATIENT DAYS	641,706	10	214,995	167,138	61,449	20,588	9
10	24 EDUCATION & SEMINAR	PATIENT DAYS	641,706	10	3,219		61,449	308	10
11	25 OTHER ADMIN. STAFF TRANS	PATIENT DAYS	641,706	10	20,755		61,449	1,987	11
12	26 INSURANCE	PATIENT DAYS	641,706	10	7,541		61,449	722	12
13	27 EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	641,706	10	32,233		61,449	3,087	13
14	30 DEPRECIATION	PATIENT DAYS	641,706	10	29,623		61,449	2,837	14
15	32 INTEREST	PATIENT DAYS	641,706	10	26,178		61,449	2,507	15
16	33 REAL ESTATE TAXES	PATIENT DAYS	641,706	10	39,087		61,449	3,743	16
17	35 EQUIPMENT RENTAL	PATIENT DAYS	641,706	10	42,473		61,449	4,067	17
18									18
19	35 LEASED EQUIPMENT	LEASING INCOME	24,090	1					19
20	30 DEPRECIATION	LEASING INCOME	24,090	1	91,098				20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 925,360	\$ 500,323		\$ 79,888	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.Street Address 6840 N. LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number ( 847) 675 -7979Fax Number ( 847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	DIETARY SALARIES	PATIENT DAYS	641,706	10	\$ 63,448	\$ 63,448	61,449	\$ 6,076	1
2	EMP. BEN.-DIETARY	PATIENT DAYS	641,706	10	13,496		61,449	1,292	2
3	ADMIN./LEGAL SALARIES	PATIENT DAYS	641,706	10	522,936	522,936	61,449	50,076	3
4	FINANCIAL CONSULTANT	PATIENT DAYS	641,706	10	135,472		61,449	12,973	4
5	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	641,706	10	\$ 78,674	\$	61,449	\$ 7,534	5
6									6
7	17 ADMIN. SALARY	AVG HRS WKD	30	5	170,502	170,502			7
8	27 EMP. BEN.-ADMIN.	AVG HRS WKD	30	5	28,886				8
9					\$	\$		\$	9
10	17 ADMIN SALARY	AVG HRS WKD	30	5	151,372	151,372			10
11	27 EMP. BEN.-ADMIN.	AVG HRS WKD	30	5	28,244				11
12									12
13	10A SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 62,910	\$ 62,910	9,012	\$ 5,262	13
14	15 EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	107,736	7	13,382		9,012	1,119	14
15									15
16	6 REPAIRS AND MAINT.	MAINTENANCE INC.	163,332	10	111,809	111,809	13,608	9,315	16
17	7 EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	163,332	10	23,783		13,608	1,981	17
18									18
19	1 DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	79,717	79,717	13,200	8,391	19
20	7 EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	17,031		13,200	1,793	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,501,663	\$ 1,162,695		\$ 105,812	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 104,873	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 104,873	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Maplewood Care# 0040428 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLC  
 Street Address 2201 MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 DIETARY	Direct Allocation			\$	\$		\$	1
2	02 FOOD	Direct Allocation							2
3	03 HOUSEKEEPING	Direct Allocation						3,415	3
4	04 LAUNDRY	Direct Allocation							4
5	06 REPAIRS & MAINTENANCE	Direct Allocation							5
6	10 NURSING	Direct Allocation						44,672	6
7	10A THERAPY	Direct Allocation							7
8	12 SOCIAL SERVICE	Direct Allocation							8
9	21 CLERICAL & GENERAL OFFICE	Direct Allocation							9
10	22 EMPLOYEE BENEFITS	Direct Allocation							10
11	39 ANCILLARY	Direct Allocation							11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 48,087	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care # 0040428 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	CIB Bank		X	Facility Improvement	\$15,115.00	7/00	\$ 600,000	\$ 59,868	7/04	Prime	\$ 6,581	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule										516,000	5	
	Working Capital												
6	CIB Bank		X	Working Capital		6/20/03		2,360,000	8/20/04	5.25%	97,211	6	
7												7	
8	See Supplemental Schedule										3,169	8	
9	TOTAL Facility Related				\$15,115.00		\$ 600,000	\$ 2,419,868				\$ 622,961	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$				\$	14
15	TOTALS (line 9+line14)						\$ 600,000	\$ 2,419,868				\$ 622,961	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Alloc. Maplewood-Jane, LLC		X				\$	\$			\$	516,000	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term											516,000	7
	Working Capital												
8							\$	\$			\$		8
9	Alloc. Preferred Bk.		X									662	9
10	Allocate SIR Mgmt		X									2,507	10
11													11
12													12
13													13
14	TOTAL Working Capital											3,169	14
	B. Non-Facility Related*												
15							\$	\$			\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Maplewood Care**# **0040428**

Report Period Beginning:

**01/01/03**

Ending:

**12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.	\$	<b>92,700</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>103,201</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>10,501</b>	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>101,100</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	<b>134</b>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>111,735</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998	<b>80,608</b>	8
	1999	<b>85,194</b>	9
	2000	<b>87,263</b>	10
	2001	<b>89,959</b>	11
	2002	<b>97,223</b>	12
<b>Accrual = \$97,223 X 1.04 = \$101,100</b>			
<b>Allocate Sir Mgmt \$3,743</b>			
<b>Allocate Preferred Bk. \$2,235</b>			
	13	FROM R. E. TAX STATEMENT FOR 2002 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Maplewood Care COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0040428

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-15-304-015</u>	<u>Long Term Care</u>	\$ <u>97,223.08</u>	\$ <u>97,223.08</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>74,287.87</u>	\$ <u>5,252.18</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>171,510.95</u>	\$ <u>102,475.26</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?   X   YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Maplewood Care COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0040428

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.

Square Feet:

36,780

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

C.

Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

16,587

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1993	\$ 262,479	1
2					2
3	TOTALS			\$ 262,479	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1993		98,204		20	3,593	3,593	40,572	9
10	Various		1994		13,684		20	684	684	7,102	10
11	Various		1995		5,179		20	259	259	2,192	11
12	Various		1996		19,800		20	990	(990)	7,755	12
13	Various		1997		21,688		20	1,085	1,085	7,429	13
14	Various		1998		19,077		20	955	955	5,042	14
15	Various		1999		47,028		20	2,195	2,195	9,613	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	4	5	6	7	8	9	
	Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37				\$	\$		\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)			5,445,306	15,921		15,921		2,026,408	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)			83,263	2,833		3,291	458	27,918	68
69	Financial Statement Depreciation				78,789			(78,789)		69
70	TOTAL (lines 4 thru 69)			\$ 5,753,229	\$ 97,543		\$ 28,973	\$ (70,550)	\$ 2,134,031	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	34

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12I, Carried Forward		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
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22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12J, Carried Forward		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807
2								
3								
4								
5								
6								
7								
8								
9								
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11								
12								
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22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 6,429,033	\$ 97,543		\$ 63,873	\$ (33,670)	\$ 2,256,807

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	203		1993		\$ 5,445,306	\$ 15,921		\$ 15,921	\$	\$ 2,026,408	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.
 See Page 12A-BLDG, Line 70 for total

\*\*Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,445,306	\$ 15,921		\$ 15,921	\$	\$ 2,026,408	70

Facility Name & ID Number Maplewood Care# 0040428

Report Period Beginning:

01/01/03

Ending:

12/31/03**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	SIR		1993		\$ 25,588	\$ 812	35	\$ 731	\$ (81)	\$ 7,676	4
5	SIR		1993		15,277	485	35	436	(49)	4,583	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Preferred Bookkeeping - Allocation		1997		19,079	427	20	954	527	6,495	9
10	Preferred Bookkeeping - Allocation		1999		151	-		8	8	34	10
11	Preferred Bookkeeping - Allocation		2000		957	-	20	48	48	163	11
12											12
13	SIR Properties - SIR Management		2002		101	-	20	5	5	8	13
14	SIR Properties - SIR Management		1999		3,242	324	20	162	(162)	730	14
15	SIR Properties - SIR Management		1998		1,549	155	20	77	(78)	426	15
16	SIR Properties - SIR Management		1997		96	10	20	5	(5)	36	16
17	SIR Properties - SIR Management		1994		244	6	20	12	6	116	17
18	SIR Properties - SIR Management		1993		415	7	20	21	14	218	18
19											19
20	SIR Properties - Preferred Bookkeeping		2002		61	-	20	3	3	5	20
21	SIR Properties - Preferred Bookkeeping		1999		1,936	194	20	97	(97)	436	21
22	SIR Properties - Preferred Bookkeeping		1998		925	93	20	45	(48)	254	22
23	SIR Properties - Preferred Bookkeeping		1997		58	6	20	3	(3)	22	23
24	SIR Properties - Preferred Bookkeeping		1994		146	4	20	7	3	69	24
25	SIR Properties - Preferred Bookkeeping		1993		248	4	20	12	8	130	25
26											26
27	SIR Management		1993		10,990	306	20	553	247	5,994	27
28	SIR Management		1994		34	-	20	3	3	32	28
29	SIR Management		1995		251	-	20	13	13	106	29
30	SIR Management		1999		1,194	-	20	60	60	252	30
31	SIR Management		2000		721	-	20	36	36	133	31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 83,263	\$ 2,833		\$ 3,291	\$ 458	\$ 27,918	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 65,590	\$ 1,967	\$ 3,782	\$ 1,815	10	\$ 52,481	71
72	Current Year Purchases	18,087	466	672	206	10	672	72
73	Fully Depreciated Assets	150,833				10	150,833	73
74								74
75	TOTALS	\$ 234,510	\$ 2,433	\$ 4,454	\$ 2,021		\$ 203,986	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,926,022	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,976	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,327	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (31,649)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,460,793	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 11,675

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Chevy Express Van	\$ 432.65	\$ 5,192	17
18					18
19					19
20					20
21	TOTAL		\$ 432.65	\$ 5,192	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2004 \$                     

13.                      /2005 \$                     

14.                      /2006 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 14,583	\$		\$ 14,583	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			105			105	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			13,758			13,758	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				27,586		27,586	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					3,384		3,384	12
13	Other (specify): See Supplemental					559	18,033		18,592	13
14	TOTAL			\$		\$ 29,005	\$ 49,003		\$ 78,008	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 57,195	\$ 57,196	1
2	Cash-Patient Deposits	41,127	41,127	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,175,215	1,175,215	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments		2,040	5
6	Prepaid Insurance	25,588	25,588	6
7	Other Prepaid Expenses	6,588	61,155	7
8	Accounts Receivable (owners or related parties)	20,300	20,300	8
9	Other(specify): <a href="#">See Attached Schedule</a>	81,313	101,613	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,407,326	\$ 1,484,234	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		517,253	13
14	Buildings, at Historical Cost		9,827,799	14
15	Leasehold Improvements, at Historical Cost	582,981	582,981	15
16	Equipment, at Historical Cost	726,482	1,335,482	16
17	Accumulated Depreciation (book methods)	(707,802)	(3,365,765)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		36,663	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>	487,200	487,200	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,088,861	\$ 9,421,613	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,496,187	\$ 10,905,847	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 114,325	\$ 114,325	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,371	44,371	28
29	Short-Term Notes Payable	2,360,000	2,360,000	29
30	Accrued Salaries Payable	214,131	214,131	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,833	20,833	31
32	Accrued Real Estate Taxes(Sch.IX-B)	101,100	101,100	32
33	Accrued Interest Payable	3,863	3,863	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	73,046	11,634,598	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,931,669	\$ 14,493,221	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	59,868	59,868	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 59,868	\$ 59,868	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,991,537	\$ 14,553,089	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (495,350)	\$ (3,647,242)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,496,187	\$ 10,905,847	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(199,284)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(199,284)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(296,066)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(296,066)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(495,350)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/03Ending: 12/31/03

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,385,096	1
2	Discounts and Allowances for all Levels	8,418	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,393,514	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	92,574	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 92,574	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	26,457	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,235	19
20	Radiology and X-Ray	1,661	20
21	Other Medical Services	12,505	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 42,858	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	1,237	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,237	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,530,183	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,172,984	31
32	Health Care	2,445,506	32
33	General Administration	1,203,792	33
<b>B. Capital Expense</b>			
34	Ownership	814,816	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	78,008	35
36	Provider Participation Fee	111,143	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,826,249	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(296,066)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (296,066)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/03Ending: 12/31/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,837	2,102	\$ 63,787	\$ 30.35	1
2	Assistant Director of Nursing	1,949	2,157	55,559	25.76	2
3	Registered Nurses	20,591	21,855	521,727	23.87	3
4	Licensed Practical Nurses	4,729	5,296	111,038	20.97	4
5	Nurse Aides & Orderlies	54,884	56,584	678,725	11.99	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,971	12,343	138,980	11.26	8
9	Activity Director	1,957	2,086	28,699	13.76	9
10	Activity Assistants	7,150	7,643	55,835	7.31	10
11	Social Service Workers	10,649	11,555	131,062	11.34	11
12	Dietician					12
13	Food Service Supervisor	1,898	2,086	41,666	19.97	13
14	Head Cook	3,252	3,560	27,122	7.62	14
15	Cook Helpers/Assistants	20,073	21,381	147,281	6.89	15
16	Dishwashers					16
17	Maintenance Workers	4,046	4,438	65,056	14.66	17
18	Housekeepers	25,368	27,412	189,417	6.91	18
19	Laundry	6,546	7,029	47,204	6.72	19
20	Administrator	1,949	2,086	57,230	27.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,924	16,793	168,576	10.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,905	3,482	53,321	15.31	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,734	3,734	9,613	2.57	33
34	TOTAL (lines 1 - 33)	201,412	213,622	\$ 2,591,898 *	\$ 12.13	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 13,200	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	96	4,128	10-03	37
38	Nurse Consultant		40,200	10-03	38
39	Pharmacist Consultant	36	2,203	10-03	39
40	Physical Therapy Consultant	Monthly	13,385	10a-03	40
41	Occupational Therapy Consultant	Monthly	4,142	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	203	10a-03	43
44	Activity Consultant	56	2,688	11-03	44
45	Social Service Consultant	100	5,473	12-03	45
46	Other(specify) <u>Dir of Food Service</u>	Monthly	20,712	01-03	46
47	<u>Psycho Social</u>	40	1,920	12-03	47
48	<u>Psychiatric Director</u>	Monthly	7,200	10a-03	48
49	TOTAL (lines 35 - 48)	334	\$ 121,454		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8,166	\$ 363,848	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	3,981	60,844	10-03	52
53	TOTAL (lines 50 - 52)	12,147	\$ 424,692		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care# 0040428Report Period Beginning: 01/01/03Ending: 12/31/03

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jamie Lloyd	Administrator	0	\$ 57,230	Workers' Compensation Insurance	\$ 49,302	IDPH License Fee	\$	
				Unemployment Compensation Insurance	21,013	Advertising: Employee Recruitment	12,440	
				FICA Taxes	194,477	Health Care Worker Background Check	564	
				Employee Health Insurance	60,461	(Indicate # of checks performed <u>47</u> )		
				Employee Meals	31,043	Dues - IL Council	6,884	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses	2,065	
				401K Contributions	3,925	Alloc. Preferred	194	
				Other Employee Benefits	8,824	Alloc. SIR Mgmt	74	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 57,230					
B. Administrative - Other								
Description			Amount					
Ancillary Administrative - SIR Management			\$ 45,648			Less: Public Relations Expense	( )	
Director of Administrative Services - SIR Management			25,584			Non-allowable advertising	( )	
ECM Owners Council - Management Fees			4,320			Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 75,552	TOTAL (agree to Schedule V, line 22, col.8)	\$ 369,045	TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	
Preferred Bookkeeping	Bookkeeping Services		\$ 73,080				Out-of-State Travel	
Preferred Bookkeeping	Computer Services		4,872					
SIR Management	Dir. Of Regulatory Serv.		16,440				In-State Travel	
SIR Management	Legal		4,872					
FR&R	Accounting		14,656					
Preferred Bookkeeping	Accounting		28,150				Seminar Expense	
Chuhak & Tecson	Accounting		630				Alloc. Preferred	
LTC Solutions	Computer Services		1,320				Alloc. SIR Mgmt	
ICS Solutions	Website		165					
Personnel Planners	Unemployment Consultant		2,482				Entertainment Expense	
Morton Cohen	Purchase Consultant		1,665				(agree to Sch. V, line 24, col. 8)	
See Supplemental Schedule			91,741					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 240,073				TOTAL	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2		3		4		5		6		7		8		9		10		11		12		13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year																				
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008												
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2																									
3																									
4																									
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19																									
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Maplewood Care

STATE OF ILLINOIS

# 0040428

Report Period Beginning:

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council \$9,373
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,381 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES \_\_\_\_\_ NO \_\_\_\_\_
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 111,143  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 31,043 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.